FOR OHF USE

LL1

2000
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2000)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0016220

Facility Name: APOSTOLIC CHRISTIAN TIMBER RIDGE

Address: 2125 VETERANS RD (Number) MORTON (City) 61550 (Zip Code)

County: TAZEWELL

Telephone Number: 309-266-9781 **Fax #** 309-266-9468

IDPA ID Number: 23-7033585-001

Date of Initial License for Current Owners: 10/10/71

Type of Ownership:

X	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
X	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code	501(c) (3)		Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: MATT STEFFEN **Telephone Number:** 309-266-9781

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 7/1/99 to 6/30/00 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) RON MESSNER
(Title) ADMINISTRATOR

Paid Preparer
(Signed) _____ (Date)
(Print Name and Title) JEROME D. MCDADE, SHAREHOLDER
(Firm Name & Address) HEINOLD-BANWART, LTD. 2400 N. MAIN, EAST PEORIA, IL 61611
(Telephone) 309-694-4251 Fax # 309-694-4202

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number APOSTOLIC CHRISTIAN TIMBER RIDGE # 0016220 Report Period Beginning: 7/1/99 Ending: 6/30/00

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds 12/1/94

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4	98	Intermediate/DD	98	35,770	4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	98	TOTALS	98	35,770	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD	32,134			32,134	11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	32,134			32,134	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 89.84%

D. How many bed-hold days during this year were paid by Public Aid?
322 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 10/01/71

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [ ] NO [X] If YES, enter number of beds certified and days of care provided

Medicare Intermediary

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 6/30/00 Fiscal Year: 6/30/00

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number APOSTOLIC CHRISTIAN TIMBER RIDGE # 0016220 Report Period Beginning: 7/1/99 Ending: 6/30/00

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	167,877	11,369	4,051	183,297	26	183,323	(61)	183,262			1
2	Food Purchase		147,414		147,414		147,414	(94)	147,320			2
3	Housekeeping	73,968	9,102		83,070		83,070		83,070			3
4	Laundry	91,749	10,667		102,416	485	102,901		102,901			4
5	Heat and Other Utilities			73,925	73,925		73,925		73,925			5
6	Maintenance	117,181	12,215	33,767	163,163	475	163,638	(16,795)	146,843			6
7	Other (specify):*											7
8	**TOTAL General Services**	450,775	190,767	111,743	753,285	986	754,271	(16,950)	737,321			8
	B. Health Care and Programs											
9	Medical Director			1,332	1,332		1,332		1,332			9
10	Nursing and Medical Records	598,667	164,505	15,979	779,151	(11,977)	767,174	(9,845)	757,329			10
10a	Therapy	1,281,603	6,178	48,424	1,336,205	(439)	1,335,766		1,335,766			10a
11	Activities	154,032	6,694		160,726	213	160,939		160,939			11
12	Social Services	170,707	5,966	6,598	183,271	48	183,319		183,319			12
13	Nurse Aide Training	23,161			23,161	6,189	29,350		29,350			13
14	Program Transportation			41,968	41,968	(6,025)	35,943	(9,845)	26,098			14
15	Other (specify):* Day Programming	71,029	1,914		72,943	(101)	72,842	(72,842)				15
16	**TOTAL Health Care and Programs**	2,299,199	185,257	114,301	2,598,757	(12,092)	2,586,665	(92,532)	2,494,133			16
	C. General Administration											
17	Administrative	63,956			63,956	(617)	63,339		63,339			17
18	Directors Fees											18
19	Professional Services			13,367	13,367		13,367		13,367			19
20	Dues, Fees, Subscriptions & Promotions			28,730	28,730		28,730	(2,331)	26,399			20
21	Clerical & General Office Expenses	107,382	24,704	11,331	143,417	2,625	146,042		146,042			21
22	Employee Benefits & Payroll Taxes			804,798	804,798		804,798		804,798			22
23	Inservice Training & Education			10,959	10,959		10,959		10,959			23
24	Travel and Seminar			2,403	2,403		2,403	(1,836)	567			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			26,099	26,099		26,099		26,099			26
27	Other (specify):*			38,322	38,322	(3,352)	34,970	(34,970)				27
28	**TOTAL General Administration**	171,338	24,704	936,009	1,132,051	(1,344)	1,130,707	(39,137)	1,091,570			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,921,312	400,728	1,162,053	4,484,093	(12,450)	4,471,643	(148,619)	4,323,024			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number APOSTOLIC CHRISTIAN TIMBER RIDGE #0016220 Report Period Beginning: 7/1/99 Ending: 6/30/00

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			126,335	126,335		126,335	(24,115)	102,220			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			2,337	2,337	(1,286)	1,051		1,051			35
36	Other (specify):*											36
37	**TOTAL Ownership**			128,672	128,672	(1,286)	127,386	(24,115)	103,271			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation					6,025	6,025	(6,025)				38
39	Ancillary Service Centers					7,711	7,711		7,711			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			245,556	245,556		245,556		245,556			42
43	Other (specify):*			2,189	2,189		2,189		2,189			43
44	**TOTAL Special Cost Centers**			247,745	247,745	13,736	261,481	(6,025)	255,456			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,921,312	400,728	1,538,470	4,860,510		4,860,510	(178,759)	4,681,751			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number APOSTOLIC CHRISTIAN TIMBER RIDGE # 0016220 Report Period Beginning: 7/1/99 Ending: 6/30/00

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$ (16,795)	6	$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs	(72,842)	15		3
4	Non-Patient Meals	(61)	1		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(34,970)	27		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(2,331)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(51,760)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (178,759)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (178,759)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.	X		$ 6,025	14	38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	**TOTAL (C): (sum of lines 38-46)**			$ 6,025		47

STATE OF ILLINOIS

Page 5A

APOSTOLIC CHRISTIAN TIMBER RIDGE

ID# 0016220

Report Period Beginning: 7/1/99

Ending: 6/30/00

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Offset day training transportation income	$ (9,845)	10	1
2	Offset day training transportation income	(9,845)	14	2
3	Non-patient meals	(94)	2	3
4	Out-of-state travel	(1,836)	24	4
5	Depreciation of non-care vehicles	(21,592)	30	5
6	Excess depreciation over straight-line	(2,523)	30	6
7	Offset medically necessary transp income	(6,025)	38	7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
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83				83
84				84
85				85
86				86
87				87
88				88
89				89
90	**Total**	(51,760)		90

STATE OF ILLINOIS

Summary A

Facility Name & ID Number APOSTOLIC CHRISTIAN TIMBER RIDGE # 0016220 Report Period Beginning: 7/1/99 Ending: 6/30/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	(61)	0	0	0	0	0	0	0	0	0	0	(61)	1
2	Food Purchase	(94)	0	0	0	0	0	0	0	0	0	0	(94)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	(16,795)	0	0	0	0	0	0	0	0	0	0	(16,795)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(16,950)	0	0	0	0	0	0	0	0	0	0	(16,950)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(9,845)	0	0	0	0	0	0	0	0	0	0	(9,845)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	(9,845)	0	0	0	0	0	0	0	0	0	0	(9,845)	14
15	Other (specify):*	(72,842)	0	0	0	0	0	0	0	0	0	0	(72,842)	15
16	**TOTAL Health Care and Programs**	(92,532)	0	0	0	0	0	0	0	0	0	0	(92,532)	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(2,331)	0	0	0	0	0	0	0	0	0	0	(2,331)	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(1,836)	0	0	0	0	0	0	0	0	0	0	(1,836)	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	(34,970)	0	0	0	0	0	0	0	0	0	0	(34,970)	27
28	**TOTAL General Administration**	(39,137)	0	0	0	0	0	0	0	0	0	0	(39,137)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(148,619)	0	0	0	0	0	0	0	0	0	0	(148,619)	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number **APOSTOLIC CHRISTIAN TIMBER RIDGE** **#** **0016220** **Report Period Beginning:** **7/1/99** **Ending:** **6/30/00**

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(24,115)	0	0	0	0	0	0	0	0	0	0	(24,115)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(24,115)	0	0	0	0	0	0	0	0	0	0	(24,115)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	(6,025)	0	0	0	0	0	0	0	0	0	0	(6,025)	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	(6,025)	0	0	0	0	0	0	0	0	0	0	(6,025)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(178,759)	0	0	0	0	0	0	0	0	0	0	(178,759)	45

Facility Name & ID Number APOSTOLIC CHRISTIAN TIMBER RIDGE # 0016220 Report Period Beginning: 7/1/99 Ending: 6/30/00

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Apostolic Christian Home for the Handicappe	100	Oakwood Estate	Morton	Community Residental Services	Morton	Residential Service for the disabled
Apostolic Christian Home for the Handicappe	100	Linden Estate	Morton			

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [ ] YES [X] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V			$			$	$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$			$	$ *	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number APOSTOLIC CHRISTIAN TIMBER RIDG # 0016220 Report Period Beginning: 7/1/99 Ending: 6/30/00

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Michael Dubach	President	Director	0.00	228	0.5		Travel	$ 623	line24; col. 3	1
2	Jerry Kieser	Sec/ Treas	Director	0.00		1					2
3	Jerry Christensen	Director	Director	0.00		0.5					3
4	Irvin Furrer	Director	Director	0.00		0.5					4
5	Ron Gasser	Director	Director	0.00	473	0.5		Travel	1,213	line24; col. 3	5
6	John Knobloch	Director	Director	0.00		0.5					6
7	Edward Sauder	Director	Director	0.00		0.5					7
8	Dan Schumacher	Director	Director	0.00		0.5					8
9	Richard Steffen	Director	Director	0.00		0.5					9
10											10
11											11
12											12
13								TOTAL	$ 1,836		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number APOSTOLIC CHRISTIAN TIMBER RIDGE # 0016220 Report Period Beginning: 7/1/99 Ending: 6/30/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number APOSTOLIC CHRISTIAN TIMBER RIDGE # 0016220 Report Period Beginning: 7/1/99 Ending: 6/30/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$	$			$	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$			$	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number APOSTOLIC CHRISTIAN TIMBER RIDGE **#** 0016220 **Report Period Beginning:** 7/1/99 **Ending:** 6/30/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 1999 report.	$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	2
3. Under or (over) accrual (line 2 minus line 1).	$	3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$	5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For 19 Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
	1995	8
	1996	9
	1997	10
	1998	11
	1999	12

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 1999	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

Facility Name & ID Number APOSTOLIC CHRISTIAN TIMBER RIDGE # 0016220 Report Period Beginning: 7/1/99 Ending: 6/30/00

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 50,135 B. General Construction Type: Exterior Brick Frame Fireproof building Number of Stories 1

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

Oakwood Estate (IDPA #0033712) is located adjacent to this property.
Type of business - Nursing Home (16 bed, ICF/ DD)
Square footage - Land 91,781; Building - 7,140 sq. ft.

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Nursing Home	1,345,699	1969	$ 54,397	1
2					2
3	TOTALS	1,345,699		$ 54,397	3

Facility Name & ID Number APOSTOLIC CHRISTIAN TIMBER RIDGE # 0016220 Report Period Beginning: 7/1/99 Ending: 6/30/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	44			1973	$ 650,091	$ 15,856	40	$ 16,252	$ 396	$	4
5	54			1978	1,016,439	25,722	40	25,411	(311)		5
6											6
7											7
8											8
	Improvement Type**										
9	Sprinklers, smoke detectors			1977	15,687	392	40	392			9
10	Conference room			1979	20,973	549	40	549			10
11	Front entrance			1981	6,308	158	40	158			11
12	Sprinklers, security system			1982	7,002	175	40	175			12
13	Energy system			1983	5,725	143	40	143			13
14	Interior remodeling			1984	8,655	216	40	216			14
15	Storage addition			1985	25,692	642	40	642			15
16	Windows, furnace, improvements			1986	11,626	291	40	291			16
17	Redocorating, furnace, improvements			1987	42,953	1,074	40	1,074			17
18	Compressor, addition, office			1988	28,487	712	40	712			18
19	Office, patio, improvements			1989	63,735	1,299	40	1,593	294		19
20	Flooring			1990	23,903	598	40	598			20
21	Roof, ceiling, flooring			1991	11,832	296	40	296			21
22	Flooring & improvements			1992	14,999	375	40	375			22
23	Roof			1994	31,810	795	40	795			23
24	Roofing			1995	17,217	430	40	430			24
25	Heat pump			1995	5,208	130	40	130			25
26	Remodel living room, lumber, windows			1995	10,408	261	40	261			26
27	Patio cover			1996	3,750	94	40	94			27
28	Magnetic Doors			1996	3,321	83	40	83			28
29	Floor covering			1997	850	21	40	21			29
30	Heat pumps & air conditioning units			1997	22,367	559	40	559			30
31	Heat pump & a/c installation			1998	2,696	67	40	67			31
32	Floor covering			1998	985	25	40	25			32
33	Wallpaper			1998	924	23	40	23			33
34	Bathroom remodeling			1998	1,657	41	40	41		1,157,331	34
35											35
36	TOTAL (lines 4 thru 35)				$ 2,055,300	$ 51,027		$ 51,406	$ 379	$ 1,157,331	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number APOSTOLIC CHRISTIAN TIMBER RIDGE # 0016220 Report Period Beginning: 7/1/99 Ending: 6/30/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Land Improvements:										9
10	Improvements			1973	59,427		20			59,427	10
11	Drive, fence			1973	6,847		20			6,847	11
12	Landscaping			1974	30,551		20			30,551	12
13	Various			1975	18,646		20			18,646	13
14	Picnic area			1981	1,060	50	20	53	3	1,045	14
15	Fence			1982	5,880	280	20	294	14	5,147	15
16	Fence			1985	565	27	20	28	1	478	16
17	Patio			1985	1,008	48	20	50	2	781	17
18	Blacktop driveways			1986	22,000	1,048	20	1,100	52	14,385	18
19	South courtyard			1990	1,409	67	20	70	3	763	19
20	Irrigation, north courtyard			1990	2,585	123	20	129	6	1,419	20
21	Driveway, landscaping			1993	10,459	497	20	523	26	4,520	21
22	Sewer repair			1994	6,700	319	20	335	16	2,345	22
23	Tile and asphalt			1995	2,011	95	20	101	6	580	23
24	Asphalt			1997	15,136	721	20	757	36	3,027	24
25	Parking lot			1998	39,261	3,704	20	1,963	(1,741)	5,889	25
26	Repair asphalt			1999	3,500	167	20	175	8	263	26
27	Parking lot lights & installation			1999	4,000	190	20	200	10	300	27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$ 231,045	$ 7,336		$ 5,778	$ (1,558)	$ 156,413	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number APOSTOLIC CHRISTIAN TIMBER RIDGE # 0016220 Report Period Beginning: 7/1/99 Ending: 6/30/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Garage			1988	22,885	558	40	572	14		9
10	Storage Building			1973	8,047	196	40	201	5		10
11	Storage Bldg - 2nd floor			1976	1,018	25	40	25			11
12	Storage Bldg - addition			1981	4,660	114	40	117	3		12
13	Storage Bldg - addition			1982	21,622	527	40	541	14		13
14	Storage Bldg - improvements			1985	842	21	40	21			14
15	Garage door			1998	667	42	40	18	(24)	26,331	15
16											16
17	Patient hall bathroom			1999	3,610	90	40	90		135	17
18	Sprinkler heads			1999	3,690	92	40	92		138	18
19	Automatic doors			1999	9,356	224	40	234	10	351	19
20	Duct work			1999	1,082	27	40	27		41	20
21											21
22	Air conditioner			2000	1,882	23	40	24	1	24	22
23	Heat pump			2000	3,100	38	40	39	1	39	23
24	Automatic rear door			2000	1,773	21	40	22	1	22	24
25	Power panels/ generator			2000	14,000	170	40	175	5	175	25
26	Office window			2000	1,057	13	40	13		13	26
27	Exhaust fan			2000	580	8	40	7	(1)	7	27
28	Dining room remodeling			2000	10,565	129	40	132	3	132	28
29	Fire alarm relay			2000	2,400	30	40	30		30	29
30	Bathrooms - remodel			2000	22,147	269	40	277	8	277	30
31	Water coolers			2000	2,701	33	40	34	1	34	31
32	Roof Repairs			2000	1,133	14	40	14		14	32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$ 138,817	$ 2,664		$ 2,705	$ 41	$ 27,763	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number APOSTOLIC CHRISTIAN TIMBER RIDGE # 0016220 Report Period Beginning: 7/1/99 Ending: 6/30/00

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	$ 374,286	$ 35,550	$ 33,620	$ (1,930)		$ 196,379	37
38	Current Year Purchases	68,227	3,937	4,482	545		4,482	38
39	Fully Depreciated Assets	289,612	4,229	4,229			289,612	39
40								40
41	TOTALS	$ 732,125	$ 43,716	$ 42,331	$ (1,385)		$ 490,473	41

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42				$	$	$	$		$	42
43										43
44										44
45										45
46	TOTALS			$	$	$	$		$	46

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
47	Total Historical Cost	(line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	$ 3,211,684	47
48	Current Book Depreciation	(line 36,col.5 + line 41,col.2 + line 46,col.5)	$ 104,743	48
49	Straight Line Depreciation	(line 36,col.7 + line 41,col.3 + line 46,col.6)	$ 102,220	49 **
50	Adjustments	(line 36,col.8 + line 41,col.4 + line 46,col.7)	$ (2,523)	50
51	Accumulated Depreciation	(line 36,col.9 + line 41,col.6 + line 46,col.9)	$ 1,831,980	51

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52	Fully depreciated vehicles	$ 162,216	$ 8,012	$ 162,216	52
53	Capitalized repairs	42,570	5,315	18,828	53
54	1997 F250 Truck; 1998	23,102	3,850	12,285	54
55	High Top Van; 2000	34,410	2,867	2,867	55
56	1998 Ford Titan Van; 2000	18,577	1,548	1,548	56
57	TOTALS	$ 280,875	$ 21,592	$ 197,744	57

G. Construction-in-Progress

	Description	Cost	
58		$	58
59			59
60			60
61		$	61

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2001	$
13.	/2002	$
14.	/2003	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☒ NO

16. Rental Amount for movable equipment: $ 1,051 Description: food pump, oxygen
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number APOSTOLIC CHRISTIAN TIMBER RIDGE # 0016220 Report Period Beginning: 7/1/99 Ending: 6/30/00

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [X] YES [ ] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [X]
- IN OTHER FACILITY [ ]
- COMMUNITY COLLEGE [ ]
- HOURS PER AIDE 80

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [X]
- IN OTHER FACILITY [ ]
- HOURS PER AIDE 40

B. EXPENSES

ALLOCATION OF COSTS (d)

			1 Facility Drop-outs	2 Facility Completed	3 Contract	4 Total
1	Community College Tuition		$	$	$	$
2	Books and Supplies		1,387	668		2,055
3	Classroom Wages	(a)	2,636	5,046		7,682
4	Clinical Wages	(b)	4,901	10,578		15,479
5	In-House Trainer Wages	(c)	2,790	1,344		4,134
6	Transportation					
7	Contractual Payments					
8	Nurse Aide Competency Tests					
9	TOTALS		$ 11,714	$ 17,636	$	$ 29,350
10	SUM OF line 9, col. 1 and 2	(e)	$ 29,350			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	13
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	27
2. From other facilities (f)	
TOTAL TRAINED	40

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$		$	$		$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number APOSTOLIC CHRISTIAN TIMBER RIDGE # 0016220 Report Period Beginning: 7/1/99 Ending: 6/30/00

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 6/30/00 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 262,581	$ 264,381	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 4,000)	602,918	774,433	3
4	Supply Inventory (priced at 41,627)	41,627	48,435	4
5	Short-Term Investments	3,825,546	3,825,546	5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	6,586	8,934	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Employee & Other Receivables	71,145	71,752	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 4,810,403	$ 4,993,481	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	285,441	613,218	13
14	Buildings, at Historical Cost	2,194,117	3,458,882	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,013,001	1,301,412	16
17	Accumulated Depreciation (book methods)	(2,032,247)	(2,625,489)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		46,100	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(46,100)	20
21	Restricted Funds	2,667,979	2,667,979	21
22	Other Long-Term Assets (specify):	2,567,734		22
23	Other(specify): Cash value life insurance	14,335	14,335	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 6,710,360	$ 5,430,337	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 11,520,763	$ 10,423,818	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 109,018	$ 135,882	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	55,691	73,043	30
31	Accrued Taxes Payable (excluding real estate taxes)	6,767	6,767	31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation	136,772	179,490	34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 308,248	$ 395,182	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 308,248	$ 395,182	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 11,212,515	$ 10,028,636	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 11,520,763	$ 10,423,818	48

***(See instructions.)**

Facility Name & ID Number APOSTOLIC CHRISTIAN TIMBER RIDGE # 0016220 Report Period Beginning: 7/1/99 Ending: 6/30/00

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 10,857,035	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 10,857,035	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	355,480	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 355,480	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 11,212,515	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number APOSTOLIC CHRISTIAN TIMBER RIDGE # 0016220 Report Period Beginning: 7/1/99 Ending: 6/30/00

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 3,945,021	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,945,021	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants	63,938	10
11	Nurses Aide Training Reimbursements	23,928	11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	5,735	16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 93,601	23
	D. Non-Operating Revenue		
24	Contributions	617,358	24
25	Interest and Other Investment Income***	297,899	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 915,257	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See attached schedule	262,111	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 262,111	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 5,215,990	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	753,285	31
32	Health Care	2,598,757	32
33	General Administration	1,132,051	33
	B. Capital Expense		
34	Ownership	128,672	34
	C. Ancillary Expense		
35	Special Cost Centers	2,189	35
36	Provider Participation Fee	245,556	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 4,860,510	40
41	**Income before Income Taxes (line 30 minus line 40)****	355,480	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 355,480	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return?** No **If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number APOSTOLIC CHRISTIAN TIMBER RIDGE # 0016220 Report Period Beginning: 7/1/99 Ending: 6/30/00

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,913	2,063	$ 55,265	$ 26.79	1
2	Assistant Director of Nursing	1,937	1,943	36,626	18.85	2
3	Registered Nurses	16,065	17,655	309,491	17.53	3
4	Licensed Practical Nurses	11,312	12,378	197,285	15.94	4
5	Nurse Aides & Orderlies					5
6	Nurse Aide Trainees	3,171	3,171	23,161	7.30	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,862	2,091	33,819	16.17	9
10	Activity Assistants	12,136	13,451	120,213	8.94	10
11	Social Service Workers	2,940	3,215	37,637	11.71	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	1,917	2,091	25,052	11.98	14
15	Cook Helpers/Assistants	16,520	18,335	142,825	7.79	15
16	Dishwashers					16
17	Maintenance Workers	7,496	8,068	117,181	14.52	17
18	Housekeepers	8,017	8,709	73,968	8.49	18
19	Laundry	9,887	11,070	91,749	8.29	19
20	Administrator	1,598	1,738	63,956	36.80	20
21	Assistant Administrator					21
22	Other Administrative	2,445	2,759	50,791	18.41	22
23	Office Manager	1,182	1,358	21,472	15.81	23
24	Clerical	3,327	3,801	35,119	9.24	24
25	Vocational Instruction	1,105	1,213	19,064	15.72	25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	9,546	10,573	133,070	12.59	28
29	Resident Services Coordinator	1,901	2,088	41,545	19.90	29
30	Habilitation Aides (DD Homes)	108,534	117,019	1,072,453	9.16	30
31	Medical Records					31
32	Other Health C: (OT/PT/Speech)	11,490	12,702	148,541	11.69	32
33	Other(specify) (Day Programs)	6,637	7,278	71,029	9.76	33
34	TOTAL (lines 1 - 33)	242,938	264,769	$ 2,921,312 *	$ 11.03	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	96	$ 4,051	1-3	35
36	Medical Director	flat fee	1,332	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	flat fee	2,308	10-3	39
40	Physical Therapy Consultant	67	3,432	10a-3	40
41	Occupational Therapy Consultant	18	1,058	10a-3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	108	7,927	10a-3	43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify) Psychologist	38	3,078	12-3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	327	$ 23,186		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	114	$ 3,370	10-3	50
51	Licensed Practical Nurses	68	1,843	10-3	51
52	Nurse Aides	2,411	36,007	10a-3	52
53	TOTAL (lines 50 - 52)	2,593	$ 41,220		53

Facility Name & ID Number APOSTOLIC CHRISTIAN TIMBER RIDGE # 0016220 Report Period Beginning: 7/1/99 Ending: 6/30/00

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Ron Messner	Administrator	0	$ 63,956
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 63,956

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Van Ostrand	Legal	$ 122
Heinold-Banwart, Ltd.	Acctg & Consulting	13,245
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 13,367

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 35,135
Unemployment Compensation Insurance	
FICA Taxes	221,380
Employee Health Insurance	311,446
Employee Meals	73,081
Illinois Municipal Retirement Fund (IMRF)*	
Retirement Plan	146,715
Employee Physicals	2,619
Employee Promotion	14,422
TOTAL (agree to Schedule V, line 22, col.8)	$ 804,798

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	19,462
Health Care Worker Background Check	743
(Indicate # of checks performed 63)	
Vehicle & other licenses	424
Promotion	1,656
IHCA dues	3,691
Other dues & subscriptions	2,079
Chamber of Commerce dues	675
Less: Public Relations Expense	(2,331)
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 26,399

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
Board of Directors Travel	1,836
In-State Travel	
Administration Travel	567
Seminar Expense	
Less out of state travel	(1,836)
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 567

**See instructions.

Facility Name & ID Number APOSTOLIC CHRISTIAN TIMBER RIDGE # 0016220 Report Period Beginning: 7/1/99 Ending: 6/30/00

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1997	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number APOSTOLIC CHRISTIAN TIMBER RIDGE # 0016220 Report Period Beginning: 7/1/99 Ending: 6/30/00

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **IL Health Care Assn - $3,691**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10 yrs**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **39,221** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **245,556**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **Yes** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **Yes** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **73,081** Has any meal income been offset against related costs? **No** Indicate the amount. $ **N/A**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No, adjusted out**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **Yes** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **6,025**
c. What percent of all travel expense relates to transportation of nurses and patients? **95%**
d. Have vehicle usage logs been maintained? **Yes**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? Yes
Indicate the amount of income earned from providing such transportation during this reporting period. $ **57,913**

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: **N/A** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **N/A** If no, please explain. **N/A**

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.

Apostolic Christian Timber Ridge
FYE 6/30/2000 **#016220**
Subschedules

Schedule V - Costs per General Ledger

Lines	Description	Amount
43	Facility Bulletin	2,189
	Other Expenses	**2,189**

Schedule V - Reclassifications

Lines	Description	Amount Increase	Amount Decrease
21	Communication equipment rental	1,286	
35	Communication equipment rental		1,286
11	Donated labor	248	
1	Donated labor	91	
4	Donated labor	485	
6	Donated labor	627	
21	Donated labor	1,339	
10a	Donated labor	397	
12	Donated labor	165	
27	Donated labor		3,352
38	Medically necessary transportation	6,025	
14	Medically necessary transportation		6,025
13	Nurse aid trainer wages	4,134	
1	Nurse aid trainer wages		65
6	Nurse aid trainer wages		152
10	Nurse aid trainer wages		2,211
10a	Nurse aid trainer wages		836
11	Nurse aid trainer wages		35
12	Nurse aid trainer wages		117
15	Nurse aid trainer wages		101
17	Nurse aid trainer wages		617
13	Nurse aid training supplies	2,055	
10	Nurse aid training supplies		2,055
39	Dental costs	7,711	
10	Dental costs		7,711
		24,563	24,563

Schedule VI B - Non-paid workers

Lines	Description	Amount
31	Donated Labor	$ 3,352
Department	Time in Hours	Time in Dollars
Activities	45.00	247
Kitchen	16.50	90
Laundry	88.25	485
Maintenance	114.00	627
Office	244.00	1,342
PT/OT	72.25	397
Social Service Programs	30.00	164
Totals	610.00	$ 3,352

Schedule VII - Compensation Received From Other Nursing Homes

Michael Dubach - $228 - reimbursement of travel expenses received from Oakwood Estate & Linden Estate

Ron Gasser- $473 - reimbursement of travel expenses received from Oakwood Estate & Linden Estate

Sch. XV - Balance Sheet, Line 22; Other Long-Term Assets

Investment in Related Entities	2,567,734

Sch. XVII - Income Statement, Line 28; Other Revenue

Developmental training	256,909
Gain on sale of fixed assets	3,479
Farm income	1,600
Miscellaneous	123
	262,111

Sch. XVII - Income Statement, Line 41 - Income Before Taxes

Income before taxes per cost report	355,480
Loss from related parties	(109,836)
Estimated excess for year, Form 990, p.1, line 18	245,644

Schedule XIX, D - Employee Benefits and Payroll Taxes - FICA calculation

Salaries, Sch V, Line 45, Col 1	2,921,312
Add accrued wages a/o 6/30/99	32,811
Less accrued wages a/o 6/30/00	(55,961)
Add wages included in employee meal calculation	40,867
Cash basis salaries	2,939,029
FICA rate	0.0765
Calculated FICA	224,836
FICA per general ledger	221,380
Unknown variance	3,456

Sch. XX - General Information

12. Nurse Aide Trainer Wages:

Administrator	617
PT/OT	836
Activities Director	35
Head Cook	65
Maintenance	152
Nursing	2,211
Social Services	117
Day Programming	101
	4,134

14. A portion of office space is allocated to related entities based on number of beds